

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to [Section H](#) of the Pharmaceutical Schedule. For community funding, see the [Special Authority Criteria](#).

PRESCRIBER

Name:

Ward:

PATIENT:

Name:

NHI:

Plerixafor

INITIATION – Autologous stem cell transplant

Re-assessment required after 3 days

Prerequisites (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ Patient is to undergo stem cell transplantation

and

- ☐ Patient has not had a previous unsuccessful mobilisation attempt with plerixafor

and

- ☐ Patient is undergoing G-CSF mobilisation

and

- ☐ Has a suboptimal peripheral blood CD34 count of less than or equal to $10 \times 10^6/L$ on day 5 after 4 days of G-CSF treatment

or

- ☐ Efforts to collect $> 1 \times 10^6$ CD34 cells/kg have failed after one apheresis procedure

or

- ☐ Patient is undergoing chemotherapy and G-CSF mobilisation

and

- ☐ Has rising white blood cell counts of $> 5 \times 10^9/L$

and

- ☐ Has a suboptimal peripheral blood CD34 count of less than or equal to $10 \times 10^6/L$

or

- ☐ Efforts to collect $> 1 \times 10^6$ CD34 cells/kg have failed after one apheresis procedure

or

- ☐ The peripheral blood CD34 cell counts are decreasing before the target has been received

or

- ☐ A previous mobilisation attempt with G-CSF or G-CSF plus chemotherapy has failed

I confirm that the above details are correct:

Signed: Date: